

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11228		11207	
1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL DENTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL DENTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MALISSA</b> First <b>JANE</b> Middle <b>ALTFATHER</b> Last		4. DATE OF DEATH <b>Oct. 30, 1960</b> Month <b>Oct.</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1890</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Will</b>		14. MOTHER'S MAIDEN NAME <b>Susan Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John W. Altfather, Denton, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Carcinoma of rectum</b> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>E. C. H. Schoricht</b> M.D.		<b>2195 West 11th St. S. 3rd Fl. Denton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>E. C. H. Schoricht</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov. 2, 1960</b>		22b. NAME OF CEMETERY OR CREMATORY <b>Denton</b>	
22c. LOCATION (City, town, or county) (State) <b>Denton, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Moore &amp; Son</b> ADDRESS <b>Denton</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 3 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			



11224

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11208

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>High street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GENEVA</u> Middle <u>B.</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/8/17</u>	
9. AGE (In years lost birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Herbert Potts</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Ewing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-18-5062</u>		17. INFORMANT Address <u>William A. Brown, Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Probably essential</u> DUE TO (c) <u>Unknown etiology.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>Several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10 Oct. 1960</u> to <u>9 PM 10-Oct. 1960</u> , that (I) (we) last saw the deceased alive on <u>10 Oct. 1960</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Dale R. Kollman</u>				22b. DATE SIGNED <u>15-Oct-1960</u>		22c. PHYSICIAN'S NAME (Type) <u>Dale R. Kollman, M.D.</u>	
22d. ADDRESS <u>16 N. 2nd St.; Denton, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Burris Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Greenland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lenora D. Doherty</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 19 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

11229

11209

1. PLACE OF DEATH o. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henderson</b>				c. LENGTH OF STAY IN 1b <b>75 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lloyd</b> Middle <b>Archer</b> Last <b>Gooden</b>				4. DATE OF DEATH Month <b>10</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-16-1877</b>		9. AGE (In years lost birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ambrose Gooden</b>				14. MOTHER'S MAIDEN NAME <b>Emma Clements</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-01-9836</b>		17. INFORMANT <b>Carlton Gooden Henderson, Maryland</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Bronchitis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 10 1958</b> to <b>Oct. 21 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 21 1960</b> and that death occurred at <b>9A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles H. Stonesifer</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/22/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>				22d. ADDRESS <b>Greensboro, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-23-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulais</b> ADDRESS <b>Greensboro, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11225

CERTIFICATE OF DEATH

Reg. Dist. No.

11210

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>MARTHA</u> First <u>GERTRUDE</u> Middle <u>HUFFINGTON</u> Last		4. DATE OF DEATH <u>Oct. 25</u> , 19 <u>60</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>no record</u>	9. AGE (In years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>JOHN HUFFINGTON</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE HAYMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Caroline Hocking Denton</u> Address <u>Denton Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatoid Arthritis</u> <u>722.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Failure</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>October</u> , 19 <u>50</u> , to <u>October</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>October, 24</u> , 19 <u>60</u> , and that death occurred at <u>9:30 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dawson O. George</u> M.D.		ADDRESS (Street, city or town, state) <u>Denton Md.</u> DATE SIGNED <u>October 26, 1960</u>	
PHYSICIAN'S NAME (Type) <u>DAWSON O. GEORGE, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 27, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Allen</u>	22d. LOCATION (City, town, or county) <u>Allen, Maryland</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Varga</u> ADDRESS <u>Moorestown Denton</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 31 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11230

Item 8 FilmG273 10-26-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Federalsburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near American Corner</b>				d. STREET ADDRESS <b>Near American Corner</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rudolph</b> Middle <b>Adolph</b> Last <b>Nagel</b>				4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1916</b> <b>September 27, 1960</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months <b>44</b> Days <b>44</b>	IF UNDER 24 HRS. Hours <b>44</b> Min. <b>44</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Rudolph Nagel</b>				14. MOTHER'S MAIDEN NAME <b>Anna B. Nagel Seiter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-30-8371</b>		17. INFORMANT Address <b>Mrs. Anna B. Nagel RFD Federalsburg</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>196.0 Carcinoma of Skull &amp; Thoracic Spine - 10 months</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>196.0</b> DUE TO (a) <b>196.0</b> stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dawson O. George</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Dawson O. George</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 16, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton &amp; Son</b>				ADDRESS <b>Federalsburg</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 18 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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11226

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

11212

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>40 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>River Road</b>				d. STREET ADDRESS <b>River Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Elma</b> Last <b>Strawberry</b>				4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 7, 1884</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Noah Hubbard</b>				14. MOTHER'S MAIDEN NAME <b>Ida Holmes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-03-8391</b>		17. INFORMANT <b>Lillie Prattis 1435 W. 7th St., Chester, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>7 years</b> <b>7 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 23, 19 60</b> to <b>Oct. 19, 19 60</b> that (I) (we) last saw the deceased alive on <b>Oct. 5, 19 60</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H. R. Trapnell</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct. 21 '60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. R. Trapnell</b>				22d. ADDRESS <b>Federalsburg, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 22, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jonestown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Caroline County Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frempton &amp; Son</b>				ADDRESS <b>Federalsburg</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 26 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

11236

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

11236

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45 years

4. Date of death: Jan. 15, 1920

5. Place of death: Home

6. Cause of death: Heart failure

7. Duration of illness: 2 days

8. Name of attending physician: Dr. J. B. Brown

9. Name of informant: John Doe

10. Address of informant: 123 Main St., New York City

11. Signature of informant: [Signature]

12. Signature of physician: [Signature]

13. Date of certificate: Jan. 15, 1920

## 11213

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Collins Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ola</b> Middle <b>Virginia</b> Last <b>Walls</b>		4. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13. FATHER'S NAME <b>Solomon N. Harris</b>		14. MOTHER'S MAIDEN NAME <b>Sarah C. Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-9489</b>	
17. INFORMANT <b>Mrs. Jane Jarrell</b>		Address <b>Greensboro, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 10, 1957</b> to <b>Oct. 26, 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct. 26, 1960</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Stonessifer</b>		22b. DATE SIGNED <b>10/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonessifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-28-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Bouleais</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 31 '60</b>	
ADDRESS <b>Greensboro, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur B. Hester</b>	

11213

CERTIFICATE OF DEATH

11213

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